



Aged, Blind, and Disabled Medicaid Managed Care Study Considerations and Recommendations

Who we are: LeadingAge Indiana represents over 150 nonprofit organizations providing a full range of senior housing, long term care, and senior services throughout Indiana. These organizations are mission-driven, committed to providing the highest quality of life for those they serve, and dedicated to achieving the highest quality standards. Most are independent, local organizations and not part of larger multi-facility or program organizations.

Our members are focused on serving the continuum of needs of their communities, many for decades, and focus on meeting the holistic physical, social, psychological, and spiritual needs of their clients/residents. Many of our members, particularly our retirement communities, have been managing and integrating care of their clients/residents for many years.

Goals for managed care: Improving the coordination and integration of health and long term services and supports is critical for meeting the needs of our burgeoning population of seniors and persons with disabilities within the fiscal limits of individuals and the government. In serving the poorest and most vulnerable in our society, Medicaid must look at both the cost of serving this population and how to improve health outcomes and delay declines in health and functional capabilities.

Challenges to meeting these goals: Managed care has been shown to provide these benefits for the general population but experience with managed care for aged, blind, and disabled (ABD) population is limited to date. States have taken various approaches such as risk based managed care and fee-for-service managed care, focused on certain subgroups of this population, or implemented statewide or within certain geographic areas. While most of the activity to date has been just on Medicaid services, twenty-one states are implementing or plan to implement managed care programs for the dually eligible.

The following are some of the major challenges Indiana will face in designing a Medicaid managed care program for the ABD population:

1. Many of the ABD population are dually eligible for both Medicaid and Medicare. Since Medicare will pay for the bulk of the health services, it won't be possible to truly integrate and coordinate their care. Effective Medicaid managed care is likely to reduce hospitalizations which won't save Medicaid funding since Medicare pays for these services. Physicians direct most of the care the ABD population receives but would not be part of a Medicaid managed care program for the dually eligible.
2. Most of the ABD population served by Medicaid are medically complex and unstable and have cognitive deficiencies. Traditional managed care programs use on-line and telephone approaches to managing utilization. This population will need face-to-face case management from individuals skilled at assessment and communication for this population.

3. Indiana has a very successful case management system through the Area Agencies on Aging for long term services and supports. This system has expertise in assessment of the ABD population, evaluating their service needs, and knowledge of local resources to address these needs. Managed Care Organizations (MCOs) have traditionally serviced the commercial health insurance markets or women and children who are Medicaid beneficiaries needing medical care. MCOs have limited experience working with the unique and complex care needs of the ABD population.
4. Many of the services needed by this population to remain independent are not traditional medical or health care services but rather social and functional supports, even home remodeling. To truly divert beneficiaries from institutional settings, MCOs need to develop or contract for this expertise and knowledge of local resources. Problems could result if ABD clients using home and community based service providers are required to move from providers they know and trust to providers within a MCO network. These providers enter a person's home to provide care and trust is critical for successful caregiving.
5. For many of the ABD beneficiaries, one of their Medicaid services is where they live – nursing homes, assisted living facilities, and group homes. Where traditional managed care can require participants to switch to a physician within their network, for these beneficiaries the MCO would be deciding where people live, often for many years, if restrictive networks are utilized.
6. By inserting a MCO between the state and the beneficiary, there will be a reduction in the funding available to serve clients. Cost savings are most easily obtained by paying providers less or by approving fewer services neither of which addresses the goal of improving health outcomes or delaying functional declines. Since savings from reducing hospital use do not benefit Medicaid for many beneficiaries, the MCO must find other ways to reduce costs to the Medicaid system.
7. One way a MCO could reduce cost is to divert more beneficiaries from institutional placement. This raises several questions. Do the current Medicaid Waiver slot restrictions go away under a managed care approach? If so, could the MCO be required to serve many more people in home and community based settings than they are now?

Important Decisions: Indiana will be faced with important decisions in deciding whether and how Medicaid ABD managed care is implemented. Here are the critical decisions:

- Will the program be mandatory or voluntary?
- If mandatory, will there be a choice in MCOs and, if so, how will beneficiaries get help in making this selection?
- If voluntary, will Medicaid automatically enroll beneficiaries and allow opt-outs or will beneficiaries opt-in to the system. Since many in the ABD population have intellectual disabilities, dementia, or mental illness, having adequate support in making these decisions will be critical;
- Will Medicaid use a risk based or managed fee for service approach?
- Will the program allow for any willing provider and if not, what criteria will MCOs use to select their provider network?
- How will provider rates be set? What oversight will the state implement to assure that rates allow for reasonable geographic access?



- What will happen to the person residing in a non-network nursing home when they spend down to Medicaid? Will they be required to move from their home?
- Will the program be implemented for all ABD beneficiaries or only a subgroup?
- Will the program be implemented statewide or phased in geographically?
- What impact will moving nursing home ABD Medicaid beneficiaries have on the Quality Assessment and the IGT/UPL program?

Quality considerations: It will be very important to establish appropriate quality measures and methodologies to evaluate the impact of any MCO's performance. The financial incentives of a risk based managed care approach would be to reduce costs by reducing provider payments and by reducing or eliminating needed services for beneficiaries.

MCOs can be accredited by several accrediting bodies including The National Committee on Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Utilization Review Accreditation Commission (URAC). The Health Employer Data and Information Set (HEDIS) contains more than 60 performance measures and is a renowned indicator of quality in managed care today. Responsibility for HEDIS currently resides with NCQA. HEDIS, however, was designed for the commercial general health care market and doesn't adequately address quality measures pertinent to the Medicaid ABD population.

The evaluation of the MCOs must include not only health measures but also quality of life measures. Measures should include: network adequacy; timeliness of assessments, service plans and service plan revisions; disenrollment; utilization data; call monitoring; quality of care performance measures; fraud and abuse reporting; participant health and functional status; complaint and appeal actions.

Indiana has been at the forefront nationally for pay for performance to incentivize quality through the nursing home Quality Add-On. Up to \$14.30/day is available for providers with the highest ratings on a variety of quality indicators. Will the MCOs continue this system? How will MCOs evaluate potential network partners? Will quality be a priority or only cost?

CMS Guidance: CMS recently came out with guidance for states developing Medicaid Managed Care Programs. The guidance focused on the following recommendations:

- Adequate planning – Medicaid managed care for the ABD population must provide for time to assure adequate safeguards are in place for this very vulnerable population;
- Stakeholder engagement – the planning process must provide opportunities for involvement and participation by beneficiaries, advocacy groups, and providers;
- Enhance provision of home and community based services – the CMS guidance focuses on community integration and work opportunities for persons with disabilities;
- Alignment of payment structure and goals – payment incentives for both the MCOs and providers should incentivize quality;



- Support for beneficiaries – the ABD population includes many individuals with intellectual disabilities, mental illness and dementia and will need face to face assistance in such things as selecting an MCO if a choice is provided, understand provider options within networks, understand their appeal rights, and have ombudsman resources;
- Person-centered processes – involvement of the beneficiary in care planning and possibly in self-directed care was listed as essential;
- Comprehensive, integrated service package – the MCOs must develop a comprehensive service network meeting all of the needs of the beneficiaries identified in their service plan;
- Qualified providers – the guidance emphasizes both quality and access and strongly recommends that current providers be given the opportunity to participate in the managed care program;
- Participant protections – these include beneficiary rights and responsibilities, critical incident management to protect against abuse, fraud, and neglect, and a fair process for hearings and appeals; and
- Quality – as noted above, quality oversight must be specific to the unique needs of the ABD beneficiary population and not conflict with existing quality compliance systems.

This guidance, as well as the CMS Timeline for Developing a Managed Long Term Services and Supports (MLTSS) Program, should guide the state's development and implementation process.

Recommendations: The following are LeadingAge Indiana's recommendations:

- As recommended in the CMS Guidance, Medicaid must allow sufficient time for adequate planning in program design, criteria for selection of the MCO partners, development of appropriate quality measures, and for the many details related to implementation and beneficiary notifications and enrollment. As also noted in the CMS Guidance, stakeholder involvement in this process through implementation will be critical.
- Medicaid managed care for the ABD population, if implemented, should be a voluntary, opt-in program where beneficiaries choose to participate based on their perception that their care will be better coordinated and effective;
- Beneficiaries should have a choice in MCOs and should be able to switch plans;
- LeadingAge Indiana would recommend a managed fee for service approach guided by a goal of improving beneficiary care coordination and improved health outcomes without the financial incentives to cuts services or provider rates;
- Any Medicaid managed care program should require any willing Medicaid certified provider provisions. This will allow beneficiaries to maintain existing trusted home and community based service providers and allow beneficiaries residing in nursing homes and Medicaid certified assisted living to not be forced to move from their home. It also will protect the person centered approach of consumer choice in providers.
- The program should exclude long term care from managed care. This would include both nursing home care and home and community based services. The AAA Aged and Disabled Resource Center system effectively coordinates home and community based services. Efforts should focus on improving the

effectiveness and efficiency of this system through should approaches as the Community Living Program proposed by the AAAs.

- Care is already adequately coordinated in the nursing home setting and efforts are underway through Medicare to reduce hospital admissions and readmissions. These Medicare initiatives will significantly improve transitions of care over the next few years due to the financial incentives involved. Since almost all Medicaid ABD beneficiaries in nursing homes are dually eligible for Medicaid and Medicare, cost savings for Medicaid in the nursing home setting can only be obtained by reducing rates and not by reducing hospital utilization. Inclusion of nursing homes in managed care also threatens the federal funding through the Quality Assessment and the IGT/UPL program.
- Medicaid ABD managed care should focus on populations those beneficiaries are not dually eligible. This will allow greater coordination of primary and tertiary medical care with long term services and supports and offer opportunities to Medicaid saving by reducing the use of emergency rooms and hospital inpatient stays.
- If nursing homes are included in any Medicaid ABD managed care program, we recommend the following:
 - Rates should be set based on the current Medicaid nursing home reimbursement methodology, incorporating the Quality Add-on pay for performance component and other resident focused features that have been carefully worked out over the last decade;
 - Residents should not be required to move if they spend down to Medicaid in a non-network facility if the facility agrees to meet the general MCO provider requirements. Residents of a CCRC should be able to move to the nursing facility in the CCRC if the CCRC also agrees to meet the general MCO provider requirements. The CMS Guidance makes clear that the interests of persons whose Medicaid services are where they live must be protected;
 - The MDS assessments should still be the basis for acuity adjustments of the rates. MCO should not establish additional assessment requirements on top of the MDS system;
 - If any willing provider requirements are not included, MCOs must establish criteria for selecting providers that include clear quality measures.